STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
			B. WIN			06/26/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹					
VERMILLION PLACE			449 MAIN ST ANDERSON, IN 46016				
VERIVILL	LION FLACE			ANDER	3011, 111 400 10		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ACH CORRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
	This visit was fo	or a State Residential	R00	000	Please accept this plan of		
	Licensure Surve				correction for the survey of		
	Licensure burve	<i>y</i> .			6/26/12		
	Commerce data = T	ma 26, 2012					
	Survey dates: Ju	me 20, 2012					
	Facility number:						
	Provider number	r: 011970					
	AIM number: N	J/A					
	Survey Team:						
	I -	ON TO					
	Tammy Alley, R						
	Toni Maley, BS	5W					
	Census bed type:	: :					
	Residential: 41						
	Total: 41						
	Census payor typ	ne:					
	Other: 41	ρ c .					
	Total 41						
	Sample: 7						
	This state finding	g is cited in accordance					
	with 410 IAC 16						
	Quality raviary a	completed on June 27					
		completed on June 27,					
į	2012 by Bev Fau	ilkner, KN					
ı							
į							
	I		ı		I		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
			B. WING			06/26/2012	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
VEDAULIONIDIAGE			449 MAIN ST ANDERSON, IN 46016				
VERMILLION PLACE				ANDER	30N, IN 460 I6		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG			TAG		DEFICIENCY)		DATE
R0216	410 IAC 16.2-5-2	2(c)(1-4)(d)					
	Evaluation - Non						
	· ·	nd content of the evaluation					
		ed in the facility policy					
		minimum the needs					
	following:	Il include an evaluation of the					
	•	's physical, cognitive, and					
	mental status.	5 physical, cognitive, and					
		's independence in the					
	activities of daily						
	 (3) The resident's weight taken on admission and semiannually thereafter. (4) If applicable, the resident's ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to evaluate residents ability 						
			D.00	1.6			07/06/0010
			R02	16	Corrective actions are not		07/26/2012
					possible for Resident #51, being		
	to self administer	r medication and			that he was discharged on June 2, 2012. Corrective actions for Resident #1 include completing a		
	residents abilities	ties to self perform medical					
		vities of daily living for 2			Self Administration of Medicati	_	
		viewed for evaluations in			Assessment by 7-26-12 to		
		esidents #57 and #1)			determine that he is able to safely administer pre-set medications.		
	a sample of 7 (Re						
					The facility administrator or he		
	Findings include	:			designee will complete a chart		
	-				audit to determine if there are		
					other residents who require an		
	1) Dogidant #51	's alogad ropord was			assessment done to evaluate self		
		's closed record was			administration of medications, ability to complete accuchecks	.	
	reviewed on 6/26/12 at 2:00 p.m. Resident #51 was admitted to the facility				independently, weigh themselv		
					independently, provide cathete		
	on 5/13/12. Resi	ident #51's admission			care independently, and/or sel		
	diagnoses included, but were not limited				administer insulin. The director of		
	•	lisease, end stage liver			nursing or her designee will		
	disease and pulm	_			complete any assessments or		
	discase and pulli	1011a1 y 11010313.			evaluations which need to be		
					done. This will be completed by		

State Form Event ID: D2FP11 Facility ID: 011970 If continuation sheet Page 2 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATI	E SURVEY				
		A. BUILDING	00	COMP	COMPLETED				
			B. WING		06/26	6/2012			
				ADDRESS, CITY, STATE, ZIP CO	DE				
NAME OF PROVIDER OR SUPPLIER			449 MAIN ST						
VERMILLION PLACE				RSON, IN 46016					
		TATEMENT OF DEPLOYENCIES		,		(X5)			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO					
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APP	PROPRIATE	COMPLETION DATE			
TAG		<u> </u>	IAG	7-26-12.		DATE			
	Resident #51 had a 5/17/12 "Mental Status Questionnaire" which indicated he			1-20-12.					
	`			In the future, the nursing					
		advanced impairment."							
	The definition of	f this term was not		upon admission or chan	ge of				
	included on the	form.		condition as needed. The					
					Director of Nursing will be				
	Resident #51 had	d a, 4/2/12, hospital		responsible to do this.	iowad				
		om a hospital stay prior to			ssessments will be reviewed long with the 6 month level of ervice evaluation that is				
				service evaluation that is					
	admission, which indicated the resident had developed acute delirium with a			completed. The admin					
	*			will complete an audit of the					
		illness associated with elevated		assessments and evalua					
		During his delirium the		quarterly to assure comp	oliance.				
	resident had reached a level of confusion where he swallowed his hearing aid. It								
	was determined	that the resident had not							
	been taking his l	actulose at home and this							
	had contributed	to his significantly							
	elevated ammon	ia levels.							
	Resident #51 had 5/2012 physician's								
		s, included but were not							
		*							
	limited to, the following:								
	, ·	s (fingerstick blood							
	· · · · · · · · · · · · · · · · · · ·	Two times daily and call							
	the doctor if belo	ow 60 or above 400.							
	b.) Daily weights and call doctor if patient gains 3 pounds in one day or 5								
	pounds in a week	-							
	c.) Routine cath	eter care							
	2.) Roadine cath	actor ouro.							
	d) Novolin N G	ingulin) inject 5 units							
	u.) Novolin N (1	insulin) inject 5 units				1			

State Form Event ID: D2FP11 Facility ID: 011970 If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING OO COMPLETE			ETED			
		B. WIN			06/26/	2012		
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
VEDANILIONERIAGE				449 MAIN ST				
VERMILLION PLACE				ANDER	SON, IN 46016			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	subcutaneously twice daily.							
		,						
	Posidont #51 roc	ord indicated he self						
		medication after the						
	medication was	preset by home health						
	services.							
	Resident #51's c	linical record lacked:						
	resident #51 5 c.	milear record facked.						
		1 0 10						
	l '	ent/evaluation for self						
	administration of pre-set medications.							
	b.) An assessment/evaluation of the							
	resident's ability to complete accuchecks							
	and notify the physician when indicated.							
	c.) An assessme	ent/evaluation of the						
	resident's ability	to weigh himself daily						
	and inform the p	hysician of 3 to 5 pound						
	increases.	nyereran er e te e peana						
	increases.							
	· /	ent/evaluation of the						
	resident's ability	to provide catheter care						
	as needed.							
	A) An accacemo	ent/evaluation of the						
	e.) An assessment/evaluation of the							
	resident's ability	to self administer insulin.						
	The clinical record also lacked any							
	documentation r	egarding the resident						
	successfully or unsuccessfully providing the above services for himself prior to 6/3/12. A 6/3/12, 10:30 p.m., Nursing							
	Note, indicated t	he resident was very						
	l .						l .	

State Form Event ID: D2FP11 Facility ID: 011970 If continuation sheet Page 4 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 6/2012			
NAME OF I	PROVIDER OR SUPPLIER	.	STREET ADDRESS, CITY, STATE, ZIP CODE					
VERMILLION PLACE			449 MAIN ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	medications for assistance empty. The family trans hospital that eve p.m., Nursing Noresident's family resident once agammonia level a candidate for ski care facility. During a 6/26/12 Director of Nurs Resident #51 had of his abilities to medications, injugaccuchecks, comnotify the physic provide self cath 2.) Resident #1' 6/26/12 at 10:00 current diagnose limited to, a hist side deficit, diab Resident #1's cli self administered had been preset the Resident #1's cli assessment/evalue.	s record was reviewed a.m. Resident #1's s included, but were not ory of stroke with a right etics and neuropathy. nical record indicated he d his medication which						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	COMPLETED 06/26/2012				
NAME OF PROVIDER OR SUPPLIER VERMILLION PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 449 MAIN ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	medications. During a 6/26/12, 3:00 p.m., interview, the Director of Nursing (DoN) indicated Resident #1 had not been assessed for his ability to safely self administer pre-set medications.						

State Form Event ID: D2FP11 Facility ID: 011970 If continuation sheet Page 6 of 6